South Carolina Department of Disabilities and Special Needs

Authorization for PDD State Funded Program
Responsible Party Line Therapy Services

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

_____
Responsible Party's Name / **Phone Number**

Service Authorization Number_____

You are hereby authorized to provide the following service(s) to the recipient named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorizations to this provider for this service(s).

Early Intensive Behavioral Intervention Services:

EIBI Self Directed Line Therapy (H0046): _____ units/week

Start Date: _____

Service Coordinator/Early Interventionist: Name / Address / Phone Number / E-mail **(Please Print)**

_____

_____

_____

_____
Signature of person authorizing services **Date**

Original to Line Therapist **Copies to Jasper DSN Board, Responsible Party and File**

PDD Form RP 18 June 6, 2008